STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

and

THE OFFICE OF THE COMPTROLLER OF THE TREASURY

DIVISION OF STATE AUDIT

MARKET CONDUCT EXAMINATION

and

LIMITED SCOPE FINANCIAL AND COMPLIANCE EXAMINATION

OF

MEMPHIS MANAGED CARE CORPORATION

MEMPHIS, TENNESSEE

FOR THE PERIOD JANUARY 1, 2006
THROUGH DECEMBER 31, 2006

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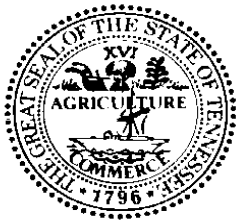

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DATE: November 8, 2007

The examination fieldwork for a Limited Scope Financial and Compliance Examination and Claims Processing Market Conduct Examination of Memphis Managed Care Corporation, Memphis, Tennessee, was completed April 19, 2007. The report of this examination is herein respectfully submitted.

I. FOREWORD

On February 20, 2007, the TennCare Division of the Tennessee Department of Commerce and Insurance (TDCI) notified Memphis Managed Care Corporation (MMCC) of its intention to perform a market conduct and limited scope financial statement and compliance examination. Fieldwork began on March 26, and ended on April 19, 2007.

This report includes the results of the market conduct examination "by test" of the claims processing system of MMCC. Further, this report reflects the results of a limited scope examination of financial statement account balances as reported by MMCC. This report also reflects the results of a compliance examination of MMCC's policies and procedures regarding statutory and contractual requirements. A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein.

II. PURPOSE AND SCOPE

A. Authority

This examination of MMCC was conducted jointly by the TennCare Division of the TDCI and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller) under the authority of Section 3-6. of the Contractor Risk Agreement (CRA) between the State of Tennessee and MMCC, Executive Order No. 1 dated January 26, 1995, and Tennessee Code Annotated (Tenn. Code Ann.) § 56-32-215 and § 56-32-232.

MMCC is licensed as a health maintenance organization (HMO) in the state and participates by contract with the state as a managed care organization (MCO) in the TennCare Program. The TennCare Program is administered by the TennCare Bureau within the Tennessee Department of Finance and Administration.

B. Areas Examined and Period Covered

The market conduct examination focused on the claims processing functions and performance of MMCC. The testing included an examination of internal controls surrounding claims adjudication, claims processing system data integrity, notification of claims disposition to providers and enrollees, and payments to providers.

The limited scope financial examination focused on selected balance sheet accounts and the TennCare income statement as reported by MMCC on its National Association of Insurance Commissioners (NAIC) annual statement for the period ended December 31, 2006, and the Medical Services Monitoring Report filed by MMCC as of December 31, 2006.

The limited scope compliance examination focused on MMCC's provider appeals procedures, provider agreements and subcontracts, the demonstration of compliance with non-discrimination reporting requirements and the Insurance Holding Company Act.

Fieldwork was performed using records provided by MMCC before and during the onsite examination of records from March 26, through April 19, 2007.

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that MMCC's TennCare operations were administered in accordance with the CRA and state statutes and regulations concerning HMO operations, thus reasonably assuring that the MMCC TennCare enrollees received uninterrupted delivery of health care services on an ongoing basis.

The objectives of the examination were to:

- Determine whether MMCC met certain contractual obligations under the CRA and whether MMCC was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. § 56-32-201 *et seq*.;

- Determine whether MMCC had sufficient financial capital and surplus to ensure the uninterrupted delivery of health care services for its TennCare members on an ongoing basis;

- Determine whether MMCC properly adjudicated claims from service providers and made payments to providers in a timely manner;

- Determine whether MMCC had implemented an appeal system to reasonably resolve appeals from TennCare providers in a timely manner; and

- Determine whether MMCC had corrected deficiencies outlined in prior examinations of MMCC conducted by TDCI.

III. PROFILE

A. Administrative Organization

MMCC was organized as a not-for-profit corporation by its sole members, Shelby County Health Care Corporation d/b/a The Regional Medical Center at Memphis (The MED) and UT Medical Group, Inc. (UTMG). MMCC was initially organized to provide for the delivery of health care services to members of the State's TennCare Program and has participated in the program since its inception on January 1, 1994. MMCC was incorporated on July 7, 1993, and was licensed as an HMO with the state on November 24, 1993. In 2006, MMCC formed MidSouth Health Services, Inc., a wholly owned subsidiary to provide administrative services, disease management services, and utilization/medical management services to MMCC's TennCare operations and other non-related companies.

The officers and board of directors for MMCC at December 31, 2006, were as follows:

Officers for MMCC

Al King, President
Steven Burchett, Chairman

Board of Directors for MMCC

Jeff Brandon
Al King
Veronica Mallett, Dr.
Stuart Polly, Dr
Judy Briggs
Brenda Jeter
Elizabeth Ostric

B. Brief Overview

Effective May 1, 2002, the CRA with MMCC was amended for MMCC to temporarily operate under a non-risk agreement. This period, otherwise known as the "stabilization period," was established to allow all MCOs a satisfactory period of time to establish financial stability, maintain continuity of a managed care environment for enrollees and assist the TennCare Bureau in restructuring the program design to better serve Tennesseans adequately and responsibly. MMCC agreed to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures

as they existed April 16, 2002, unless such a change received approval in advance by the TennCare Bureau.

During stabilization, MMCC receives from the TennCare Bureau a monthly fixed administrative payment based upon the number of TennCare enrollees assigned to MMCC. The TennCare Bureau reimburses MMCC for the cost of providing covered services to TennCare enrollees.

MMCC is currently authorized by TDCI and the TennCare Bureau to operate in the community service areas of Shelby County, Northwest Tennessee and Southwest Tennessee which comprise the West Grand Region. All premium revenue earned by MMCC is from payments received for enrollees assigned by the TennCare Bureau. As of December 31, 2006, MMCC reported enrollment of approximately 169,000 TennCare members.

C. Claims Processing Not Performed by MMCC

TennCare has contracted with other organizations for the administration and claims processing of these types of services:

- Dental
- Pharmacy
- Behavioral Health

During the period under examination, MMCC did not subcontract with vendors for the provision of specific TennCare benefits and the processing and payment of related claims submitted by providers.

IV. PREVIOUS EXAMINATION FINDINGS

The previous examination findings are provided for informational purposes. The following were financial, claims processing and compliance deficiencies cited in the examination by the TDCI, TennCare Division for the period January 1, 2005 through December 31, 2005:

A. Financial Deficiencies

1. MMCC did not report as short term investments bonds which mature in less than one year as required by Statutory Accounting Principle No.2.

2. MMCC improperly increased revenue and expenses by the same amount on the NAIC financial statements for the MedCall cost center.

3. On the NAIC financial statements, the write-in for provider advances totaling $97,000 was correctly non-admitted but should be reclassified as a healthcare receivable.

4. MMCC did not prepare the TennCare Operations Statement as if MMCC were still at risk, because it did not include reimbursements for premium taxes in either revenue or expenses as required by Section 2-10.i. of the CRA.

Finding numbered 4 above is repeated as part of this report.

B. Claims Processing Deficiencies

1. MMCC was not in compliance with prompt pay requirements of Tenn. Code Ann. §56-32-226(b) for claims processed during February 2005.

2. The following deficiencies were noted during the review of the claims payment accuracy reports:

   - As reported in the prior examination findings, the number of claims selected for testing by MMCC was not sufficient to project the results to the entire population. Only 99 claims are tested each quarter in preparation of the claims payment accuracy reports.

   - As evidenced by the third quarter 2005 report submitted, MMCC has not initiated requirement of Section 2-9.g. of the CRA effective July 1, 2005. The report was not prepared by an internal auditor. The CRA requires, at a minimum, that 100 claims be tested monthly. MMCC's third quarter report indicates only 99 claims were tested for the quarter.

3. TDCI was unable to confirm the contracted rate for one claim because MMCC was unable to locate the provider agreement.

4. MMCC does not maintain a log of rejected claims returned to providers. Without this log**,** MMCC will be unable to ensure that all claims received in the mailroom have either been processed through the system or returned to the provider.

5. For two of fourteen claims tested from the mailroom, the receipt date in the claims processing system was different from the actual date the claim was received.

Findings numbered 1 and 5 above are repeated as part of this report.

C. Compliance Deficiencies

1. Two of three provider agreements selected for testing did not contain all provisions required by Section 2-18. of the CRA.

2. Capitation payments for a quarter resulted in an overpayment to one provider for approximately $302,000.

3. MMCC lacks an internal audit department. Per Section 2-9.a.14. of the CRA effective July 1, 2005, MMCC is required to have in place the internal audit function, and specifically Section 2-9.g. requires that internal audit should be performing the claims payment accuracy testing beginning with the Third Quarter 2005 reporting due on October 30, 2005.

4. Interest earned for May through June 2005 was not returned to the State in a timely manner per Section 3-10.h.2.(d). of the CRA.

5. Subrogation amounts collected for April through June 2005 were not returned to the State in a timely manner per Sections 3-10.h.2.(f) and (g) of the CRA.

6. MMCC should establish an internal audit department to enhance compliance efforts with the conflict of interest clause of the CRA. Additionally, the organizational chart should indicate the compliance officer should report to the Board of Directors.

Findings numbered 1, 4, and 5 above are repeated as part of this report.

V. SUMMARY OF CURRENT FINDINGS

The summary of current factual findings is set forth below. The detail of testing as well as management's comments to each finding can be found in Sections VI, VII, and VIII of this examination report.

A. Financial Deficiencies

1. MMCC incorrectly reported the beginning capital and surplus balance for 2006 and the ending capital and surplus balance for 2005 on the 2006 NAIC Annual Statement, Statement of Revenues and Expenses. MMCC correctly amended the annual statement by adjusting the capital and

surplus balances on the Statement of Revenue and Expenses. (See Section VI.A.4.)

2. MMCC incorrectly reflected in the 2006 reporting period an audit adjustment for the 2005 reporting period on the 2006 Statement of Revenues and Expenses, page 2. Additionally, MMCC should have reported the audit adjustment on the 2005 NAIC annual statement. (See Section VI.A.5.)

3. The gross paid in and contributed capital balance of $3,699,498 as reported on the 2006 NAIC Annual Statement could not be traced to specific ending balances as reported on the trial balance. (See Section VI.A.6.)

4. MMCC incorrectly classified $1,349,431 in payables due to the State and $661,718 in amounts withheld or retained for the account of others as General Expenses Due or Accrued on the 2006 NAIC Annual Statement. (See Section VI.A.7.)

5. MMCC incorrectly netted provider receivables of $272,267 and provider payables due to the state for overpayments of the same amount. For NAIC statement reporting, the amounts should be reported separately as an asset and a liability. In addition, the provider receivables of $270,736 should have been non-admitted based on statutory accounting principles. (See Section VI.A.7.)

6. MMCC incorrectly classified $24,920.037 of administrative fee payments received from the TennCare Bureau as a write-in on the Underwriting and Investment Exhibit Part III - Analysis of Expenses. MMCC should have reported the administrative fee payments as reimbursements by uninsured accident and health plans. (See Section VI.A.8.)

7. MMCC incorrectly reported a donation and employee expense reimbursements of $32,431 as marketing expenses on the TennCare Operations Statement of Revenues and Expenses. (See Section VI.A.9.)

8. MMCC did not prepare the TennCare Statement of Revenues and Expenses Report 2A as if MMCC was at risk as required by the CRA. (See Section VI.B.)

9. MMCC's net worth reported on the 2006 NAIC Annual Statement was overstated by $270,736. (See Section VI.D.)

B. Claims Processing Deficiencies

1. MMCC was not in compliance with the prompt pay requirements of Tenn. Code Ann. § 56-32-226(b)(1) for claims processed during May 2006. (See Section VII.A.)

2. MMCC failed to comply with the claims payment accuracy requirements of Section 2-9. of the CRA for the fourth quarter of 2006 and the first quarter 2007. (See Section VII.C.)

3. MMCC's claims accuracy testing determined that MMCC incorrectly processed claims for Medicare dual eligible enrollees which resulted in overpayments to providers during the non-risk period. As of July 13, 2007, MMCC had identified potential overpayments totaling $4,608,588 from 2003 through 2006. (See Section VII.C.)

4. Payment rates per the claims processing system are not traced to the provider contract as part of MMCC's claims payment accuracy report preparation procedures. (See Section VII.C.2.)

5. Review of the fourth quarter 2006 claims payment accuracy testing revealed that MMCC overpaid claims to one provider by $73,497 during the non-risk period because the incorrect fee amount was loaded in the claims processing system. (See Section VII.C.2.)

6. For one of the nine claims tested from the mailroom, the receipt date in the claims processing system was different from the actual date the claim was received by MMCC. (See Section VII.M.)

C. Compliance Deficiencies

1. MMCC did not resolve all provider complaints within 30 days as required by MMCC's written policies and procedures. (See Section VIII.A.)

2. Of 19 provider contracts reviewed, 12 contracts were not in compliance with all provider contract requirements set forth in the CRA including the Section 2-18. requirements. (See Section VIII.C.)

3. For 12 of 19 provider contracts selected for testing, MMCC executed the provider contracts without prior approval from TDCI in violation of Sections 2-9.f. and 2-17. of the CRA. Provider contracts are required to be submitted to TDCI as a material modification to MMCC's certificate of authority by Tenn. Code Ann. § 56-32-203(c)(1). (See Section VIII.C.)

4. MMCC did not obtain prior approval from the TennCare Bureau or TDCI before executing subcontracts in violation of Sections 2-9.f. and 2-17. of the CRA and Tenn. Code Ann. § 56-32-203(c)(1). The subcontracts that were not submitted for approval included three agreements for provider credentialing service, three agreements for transportation administration services, and a subcontract between MMCC and its wholly-owned subsidiary for medical management services. (See Section VIII.E.)

5. Interest earned during the examination period was not returned to the State in a timely manner per Section 3-10.h.2.(d). of the CRA. (See Section VIII.K.)

6. Subrogation amounts collected during the examination period were not returned to the State in a timely manner per Sections 3-10.h.2.(f) and (g) of the CRA. (See Section VIII.K.)

VI. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial Analysis

As an HMO licensed in the State of Tennessee, MMCC is required to file annual and quarterly NAIC financial statements in accordance with NAIC and statutory guidelines with the Tennessee Department of Commerce and Insurance. The department uses the information filed on these reports to determine if MMCC meets the minimum requirement for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory accounting differs from generally accepted accounting principles because "admitted" assets must be easily convertible to cash, if necessary, to pay outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and should not be considered when calculating capital and surplus.

At December 31, 2006, MMCC reported $32,595,471 in admitted assets, $2,114,897 in liabilities and $30,480,574 in capital and surplus on its 2006 NAIC Annual Statement submitted March 1, 2007. MMCC reported total net income of $8,211,034 on its statement of revenue and expenses.

1. Capital and Surplus

Tenn. Code Ann. § 56-32-212(a)(2) requires MMCC to establish and maintain a minimum net worth equal to the greater of (1) $1,500,000 or (2) an amount totaling 4% of the first $150 million of annual premium

revenue earned for the prior calendar year, plus 1.5% of the amount earned in excess of $150 million for the prior calendar year.

Tenn. Code Ann. § 56-32-212(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives any or all of the provisions of the federal Social Security Act (title XIX), and regulations promulgated pursuant thereto, or pursuant to any other federal law as adopted by amendment to the required title XIX state plan..." Based on this definition, all TennCare payments made to an HMO licensed in Tennessee are to be included in the calculation of net worth and deposit requirements, regardless of the reporting requirements for the NAIC statements.

2006 Statutory Net Worth Calculation

MMCC's premium revenue per documentation obtained from the TennCare Bureau totaled $335,173,140 for the calendar year 2006; therefore, based upon Tenn. Code Ann. § 56-32-212(a)(2), MMCC's statutory net worth requirement for the calendar year 2006 is $8,777,597. MMCC reported total capital and surplus of $30,480,574 as of December 31, 2006, which is $21,702,977 in excess of the minimum statutory net worth requirement.

Premium Revenue for the Examination Period

For the examination period January 1 through December 31, 2006, the following is a summary of MMCC's premium revenue as defined by Tenn. Code Ann. § 56-32-212(a)(2):

Administrative fee payments from TennCare for the period January 1 through December 31, 2006	$23,306,918
Reimbursement for medical payments from TennCare for the period January 1 through December 31, 2006	305,364,281
Reimbursement for premium tax payments from TennCare for the period January 1 through December 31, 2006	6,501,941
Total premium revenue January 1 through December 31, 2006	$335,173,140

2. Restricted Deposit

Beginning July 1, 2005, an amendment to the CRA required MCOs to have on deposit an amount equal to the calculated statutory minimum net worth requirement. Based upon premium revenues for calendar year 2006 totaling $335,173,140, MMCC's statutory deposit requirement at December 31, 2006, was $8,777,597. MMCC had on file with TDCI the necessary safekeeping receipts documenting that deposits totaling $9,200,000 had been pledged for the protection of the enrollees in the State of Tennessee.

3. Claims Payable

As of December 31, 2006, MMCC reported no claims unpaid on the NAIC annual statement. This amount represented an estimate of unpaid claims or incurred but not reported (IBNR) for only the "at risk" period ending April 30, 2002. Review of the triangle lag payment report after December 31, 2006, through February 28, 2007, for dates of services before May 1, 2002 determined that the reported claims payable appears reasonable.

4. Prior Year Capital and Surplus Balance

On the Statement of Revenues and Expenses, MMCC reported on the 2006 NAIC Annual Statement $26,538,308 as the 2006 beginning capital and surplus balance. MMCC also reported $26,539,158 as the 2005 ending capital and surplus balance which does not agree to the reported 2006 beginning capital and surplus of $26,538,308. The restatement of the 2006 beginning capital and surplus balance and the 2005 ending capital and surplus balance will not have an effect on net worth. MMCC correctly amended the 2006 Annual Statement on June 4, 2007 by adjusting capital and surplus on the Statement of Revenue and Expenses.

Management Comments

MMCC Management concurs.

5. Audit Adjustment

MMCC incorrectly reported on the 2006 NAIC Annual Statement aggregate write-ins for gains or (losses) of $1,266,197 on the Statement of Revenue and Expenses, Page 2, as an adjustment to 2006 capital and surplus. Examination test work revealed the write-in was an audit

adjustment from MMCC's 2005 independent audit report for an unrecorded receivable of $645,435 and a reserve adjustment of $620,761. This audit adjustment should have been reported as an adjustment to 2005 capital and surplus. MMCC should also have reported this audit adjustment on the 2005 NAIC Annual Statement. This adjustment does not affect the reported 2006 capital and surplus. MMCC amended the 2005 and 2006 annual statements on June 4, 2007 to properly record the audit adjustment.

Management Comments

MMCC Management concurs.

6. Paid in and Contributed Surplus

MMCC's gross paid in and contributed surplus of $3,699,498 is correctly reported on the 2006 NAIC Annual Statement, but MMCC's supporting trial balance classifications of equity amounts did not agree to this amount. MMCC's trial balance reflected the following 2006 ending balances:

Beginning Fund Balance	($2,100,000)
Capital Improvement Fund Balance	$6,400,502
Total	$4,300,502

In 2005 and 2006, MMCC incorrectly recorded distributions in the capital improvements fund account versus the fund balance account. MMCC plugged the fund balance to properly report the amount on the NAIC annual statement; however, MMCC failed to correct the accounting records. MMCC should ensure that the paid in and contributed fund balance and all other reported account balances agree to the trial balance.

Management Comments

MMCC Management agrees that the NAIC Report of Beginning Balance was correct. MMCC uses the Trial Balance for all financial reporting including the NAIC report. It is sometimes necessary to make adjustments to the Trail Balance for presentation. MMCC did not separate the distributions into a separate account on the Trail Balance. This has since been changed in the Trail Balance clarify presentation for all reporting.

7. General Expenses Due or Accrued

MMCC reported general expenses due or accrued totaling $1,922,202 as of December 31, 2006. During the examination, MMCC provided a detailed listing of the account. Per TDCI's review of this listing it was determined that MMCC incorrectly included amounts in this account which were not due to trade vendors for the acquisition of goods or services. MMCC incorrectly included $1,349,431 in payables due to the State and $661,718 in amounts withheld or retained for the account of others. MMCC should only include amounts due to trade vendors in this line item. The NAIC Annual Statement Instructions defines general expenses due and accrued as "amounts due to creditors (trade vendors rather than health care providers) for the acquisition of goods and services on a credit basis."

Management Comments

MMCC Management concurs.

Further, MMCC netted in general expenses due and accrued both a receivable for credit balances due from providers totaling $272,267 and a payable due to the TennCare Bureau totaling $1,349,431. It is inappropriate for MMCC to net these accounts in the general expenses due or accrued account. CRA Section 2.9.m.12 states specific requirements for the return of provider overpayments to the TennCare Bureau. Also, Statutory Statements of Accounting Principles 84 defines strict rules for the admittance of receivables due from providers. The majority of the credit balances due from providers were over 90 days old as of the statement date and should be non-admitted from capital and surplus. MMCC amended the annual statement on June 4, 2007 to correct this reporting error. MMCC's reclassified and non-admitted provider receivables over 90 days which decreased net worth by $270,736 is reflected in examination adjustments. (See Section VI.D.)

Management Comments

MMCC Management concurs.

8. Underwriting and Investment Exhibit Part III – Analysis of Expenses

MMCC incorrectly classified $24,920.037 of administrative fee payments received from the TennCare Bureau as a write-in on the Underwriting and Investment Exhibit Part III - Analysis of Expenses. MMCC should account

for administrative fee payments received from the TennCare Bureau on Line 19, Reimbursements by uninsured accident and health plans. MMCC amended the statement on June 4, 2007 to correctly reclassify reimbursements on the exhibit. The reclassification did not affect reported net worth.

Management Comments

MMCC Management concurs.

9. Marketing Expenses

MMCC reported marketing expenses totaling $32,431 on the TennCare Operations Statement of Revenues and Expenses. Test work revealed MMCC's marketing account incorrectly included a donation and employee expense reimbursements. These amounts are not marketing expenses and should not be reported as such. MMCC amended the statement on June 4, 2007 by eliminating marketing expense. The reclassification of these expenses did not affect reported net worth.

Management Comments

MMCC Management concurs.

B. Administrative Services Only (ASO)

As previously mentioned, the CRA between MMCC and the State of Tennessee does not currently hold MMCC financially responsible for medical claims. This type of arrangement is considered "administrative services only" (ASO) by the NAIC. Under the NAIC guidelines for ASO lines of business, the financial statements for an ASO exclude all income and expenses related to claims, losses, premiums, and other amounts received or paid on behalf of the uninsured ASO. In addition, administrative fees and revenue are deducted from general administrative expenses. Further, ASO lines of business have no liability for future claim payments; thus, no provisions for IBNR are reflected on the balance sheet.

Although MMCC is under an ASO arrangement as defined by NAIC guidelines, the CRA requires a deviation from ASO reporting guidelines. The required submission of the TennCare Operating Statement should include quarterly and year-to-date revenues earned and expenses incurred as a result of the contractor's participation in the State of Tennessee's TennCare program as if MMCC were still operating at-risk. As stated in Section 2-

10.h.2. of the CRA, MMCC is to provide "an income statement detailing the CONTRACTOR's fourth quarter and year-to-date revenues earned and expenses incurred as a result of the CONTRACTOR's participation in the State of Tennessee's TennCare Program." TennCare HMOs provide this information on the Report 2A submitted as a supplement to the NAIC financial statements.

MMCC did not prepare the TennCare Operations Statement as if MMCC were still at risk, because MMCC did not report all revenues earned and expenses incurred as a result of MMCC's participation in the TennCare Program. Further, the totals on the statement were not correctly added. The deficiencies in preparing Report 2A did not affect MMCC's reported net worth or net income; however, the TennCare Operations Statement should present MMCC's operations as if MMCC were still at risk. MMCC submitted a corrected TennCare Operations Statement on June 4, 2007 by including total IBNR in reported premiums and medical expenses.

Management Comments

MMCC Management concurs.

C. Medical Services Monitoring

Effective July 1, 2002, the CRA requires MMCC to submit a Medical Services Monitoring Report (MSM) on a monthly basis. The MSM accounts for medical payments and IBNR based upon month of service as compared to a target monthly amount for the enrollees' medical expenses. Although estimates for incurred but not reported claims for ASO plans are not included in the NAIC financial statements, these estimates are required to be included in the MSM. MMCC submitted monthly MSM reports which reported actual and estimated monthly medical claims expenditures to be reimbursed by the TennCare Bureau. The estimated monthly expenditures are supported by a letter from an actuary which indicates that the MSM estimates for IBNR expenses have been reviewed for accuracy.

No discrepancies were noted during the review of documentation supporting the amounts reported on the Medical Services Monitoring Report.

D. Schedule of Examination Adjustments to Capital and Surplus

Adjustments to capital and surplus as a result of the examination are as follows:

Reported capital surplus as of December 31, 2006	$30,480,574
Non-Admitted Provider Receivables over 90 days old (See Section VI.A.7.)	(270,736)
Adjusted capital and surplus	$30,209,838

VII. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Time Study of Claims Processing

The purpose of conducting a time study of claims is to determine whether claims were adjudicated within the time frames set forth in Tenn. Code Ann. § 56-32-226(b)(1) and Section 2-18. of the CRA. The statute mandates the following prompt payment requirements:

> The health maintenance organization shall ensure that ninety percent (90%) of claims for payments for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of such claims. The health maintenance organization shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program.
>
> > (A) "Pay" means that the health maintenance organization shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health maintenance organization.
> >
> > (B) "Process" means the health maintenance organization must send the provider a written or electronic remittance advice or other appropriate written or electronic notice evidencing either that the claim had been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for denial. If a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice must specifically identify all such information and documentation.

TDCI currently determines compliance with Tenn. Code Ann. § 56-32-226(b)(1) by testing in three-month increments data file submissions from each of the TennCare MCOs. Each month is tested in its entirety for compliance with the prompt pay requirement of Tenn. Code Ann. If a TennCare MCO fails to meet the prompt pay standards in any of the three months tested, TDCI, at a minimum, requires claims data submissions on a monthly basis for the next three months to ensure the MCO remains complaint.

The prompt pay testing results for the examination period are as follows:

	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2006	99%	100.0%	**Yes**
February 2006	99%	100.0%	**Yes**
March 2006	98%	100.0%	**Yes**
April 2006	98%	99.9%	**Yes**
May 2006	94%	99.0%	**No**
June 2006	94%	99.6%	**Yes**
July 2006	97%	99.5%	**Yes**
August 2006	92%	99.6%	**Yes**
September 2006	92%	99.8%	**Yes**
October 2006	99%	99.7%	**Yes**
November 2006	99%	99.6%	**Yes**
December 2006	92%	99.6%	**Yes**

MMCC processed claims timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1) for claims processing requirements for the months of January through April, 2006, and June through December 2006. However, MMCC did not process claims timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1) for the month of May 2006.

Management Comments

MMCC Management concurs. MMCC would also like to note that it was only deficient in one measure and this measure was deficient by only .5%.

B. Determination of the Extent of Test Work on the Claims Processing System

Several factors were considered in the determination of the extent of testing performed on MMCC's claims processing system.

The following items were reviewed to determine the risk that MMCC had not properly processed claims:

- Prior examination findings related to claims processing
- Complaints or independent reviews on file with TDCI related to inaccurate claims processing
- Results of prompt pay testing by TDCI
- Results reported on the claims payment accuracy reports submitted to TDCI and the TennCare Bureau
- Review of the preparation of the claims processing accuracy reports
- Review of internal controls

As noted below, TDCI discovered deficiencies related to MMCC's procedures for preparing the claims payment accuracy reports. The deficiencies resulted in an increase in TDCI's substantive testing.

C. Claims Payment Accuracy Report

Section 2-9. of the CRA requires that 97% of claims are paid accurately upon initial submission. MMCC is required to submit quarterly a claims payment accuracy report 30 days following the end of each quarter.

MMCC reported the following results for calendar year 2006:

	Results Reported	Compliance
First Quarter 2006	97.1%	**Yes**
Second Quarter 2006	97.5%	**Yes**
Third Quarter 2006	97.8%	**Yes**
Fourth Quarter 2006	95.6%	**No**

During the examination period, MMCC was in compliance with Section 2-9 of the CRA, with the exception of the fourth quarter of 2006.

MMCC submitted a corrective action plan along with the fourth quarter 2006 claims payment accuracy report. The corrective action plan indicated that most of the claims that were inaccurately paid were Medicare dual eligible claims. MMCC updated the corrective action plan on March 28, 2007, which indicated workgroups were established to determine the cause of the errors.

Subsequent to the examination period, for the first quarter of 2007, MMCC's claims payment accuracy rate was 96% which was still not in compliance with CRA Section 2-9 requirements. TDCI requested a corrective action plan. MMCC submitted a corrective action plan on May 14, 2007. The corrected action plan stated that claims processing system changes had been implemented, the claims processing system support vendor was working on programming changes, and additional training classes will address manual claims processing errors. MMCC was in compliance with claims payment accuracy requirements for the second quarter of 2007.

Management Comments

MMCC Management concurs with this finding. Management requested programming changes from our support vendor. These changes have been implemented. Necessary system corrections have also been implemented at TLC. Weekly claim audits are conducted to determine claim payment accuracy rates and are used by Management to determine additional system corrections which need to be implemented to allow for claim payment accuracy.

As of July 13, 2007, MMCC had identified potential overpayments on claims for Medicare dual eligible enrollees totaling $4,608,588 from 2003 through 2006. As a result, MMCC notified providers that overpayments had occurred and made recoupments. The TennCare Bureau and TDCI continue to monitor MMCC's efforts to identify further overpayments .

Management Comments

MMCC Management concurs. Further, MMCC's dual eligible claim recoupment process will be fully complete in early November 2007. MMCC will update both the Bureau of TennCare and TDCI as to the final results.

1. Procedures to Review the Claims Payment Accuracy Reporting

The review of the claims processing accuracy report included an interview with responsible staff to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy report. These interviews were followed by a review of the supporting documentation used to prepare the fourth quarter 2006 claims payment accuracy report. In addition 20 claims were selected at random by TDCI from MMCC's fourth quarter claims payment accuracy report for review. This review included verification that the number of claims selected by MMCC constituted an adequate sample to represent the population. The selected claims were reviewed to determine that the information on the supporting documentation was correct. The supporting documents were tested for mathematical accuracy. The amounts from the supporting documentation were compared directly to the actual report filed with TennCare. Also, all claims identified in the report with errors were reviewed to ensure the errors have been corrected.

2. Results of Review of the Claims Payment Accuracy Reporting

The following deficiencies were noted during the review of the claims payment accuracy reports.

- Payment rates per the claims processing system are not compared to the provider contract as part of MMCC's claims payment accuracy report preparation procedures.

- Test work revealed that for one of 20 claims tested, a payment rate in the claim system did not agree with the fee schedule in the provider contract. As a result of this error, MMCC's internal audit department reviewed the claim history related to this provider. MMCC found that $73,497.46 in overpayments for the period May 1, 2002 through May 31, 2007, should be recouped because the incorrect payment rate was loaded in the claims processing system.

Management Comments

MMCC Management concurs with this finding. Internal Audit had not been auditing professional claim lines to the provider's written contract. In July 2007, Internal Audit began auditing all claim lines for pricing accuracy. Claim payment accuracy rates which include auditing back to the provider contract will be reported to TDCI beginning with the 3rd Quarter of 2007.

MMCC Management concurs with this finding. Necessary recoupments of overpayments were conducted for this provider.

D. Claims Selected For Testing From Prompt Pay Data Files

Sixty claims were selected from the October 2006 prompt pay data files previously submitted to TDCI. For each claim processed, the data files included the date received, date paid, the amount paid, and if applicable, an explanation for denial of payment.

The number of claims selected for testing was not determined statistically. The results of testing are not intended to represent the percentage of compliance or non-compliance for the total population of claims processed by MMCC.

To ensure that the October 2006 data files included all claims processed in the month, the total amount paid per the data files was reconciled to the triangle lags and to the general ledger for the respective accounting periods to within an acceptable level.

E. Comparison of Actual Claim with System Claim Data

The purpose of this test is to ensure that the information submitted on the claim was entered correctly in MMCC's claims processing system. Attachment XII Exhibit G of the CRA requires minimum data elements to be recorded from medical claims and submitted to TennCare as encounter data. Original hard copy claims were requested for the sixty claims tested. If the claim was submitted electronically, the original electronic submission file associated with the claim was requested.

The data elements recorded on the claims were compared to the data elements entered into MMCC's claims processing system. No discrepancies were noted between the information submitted on the claims and the data recorded in MMCC's system.

F. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied, or rejected. There were no discrepancies noted with the sixty claims tested.

G. Price Accuracy Testing

The purpose of price accuracy testing is to determine whether payments for specific procedures are in accordance with the system price rules assigned to providers, whether payments are in accordance with provider contracts, and whether amounts are calculated correctly. There were no discrepancies noted with the sixty claims tested.

H. Copayment Testing

The purpose of testing copayment is to determine if enrollees are subject to out-of-pocket payments for certain procedures, if out-of-pocket payments are within liability limitations, and if out-of-pocket payments are accurately calculated. Because the sixty claims selected for testing did not include any claims with copays, examiners expanded testing and reviewed the claims history for 2006 for five enrollees with copayments. No discrepancies were noted in the review of these claims.

I. Remittance Advice Testing

The purpose of remittance advice testing is to determine whether remittance advices sent to providers accurately reflect the processed claim information in the system.

The examiners requested remittance advices for ten of the sixty claims selected for testing to compare the payment and/or denial reasons per the claims processing system to the information communicated to the providers. No discrepancies were noted between the claims payment per the claims processing system and the related information communicated to the providers.

J. Analysis of Cancelled Checks

The purpose of analyzing cancelled checks is to: (1) verify the actual payment of claims by MMCC; and (2) determine whether a pattern of significant lag times exists between the issue date and the cleared date on the checks examined.

The examiners requested cancelled checks for ten claims which were also selected for remittance advice testing. MMCC provided the cancelled checks. The check amounts agreed with the amounts paid per the remittance advice and no pattern of significant lag times between the issue date and the cleared date was noted.

K. Pended and Unpaid Claims Testing

The purpose of analyzing pended claims is to determine if a significant number of claims are unprocessed and as a result a material liability exists for the unprocessed claims.

The pended and unpaid data file submitted to TDCI as of January 31, 2007 indicated that 3,065 claims exceeded 60 days. No material liability exists for claims over 60 days.

L. Electronic Claims Capability

Section 2-9.g. of the CRA states, "The CONTRACTOR shall have in place a claims processing system capable of accepting and processing claims submitted electronically with the exception of claims that require written documentation to justify payment …." The electronic billing of claims allows the MCO to process claims more efficiently and cost effectively.

The Health Insurance Portability and Accountability Act, Title II (HIPAA) requires that all health plans be able to transmit and accept all electronic transactions in compliance with certain standards as explained in the statute by October 15, 2002. The U.S. Department of Health and Human Services extended the deadline until October 15, 2003, for health plans requesting additional time. Failure to comply with the standards defined for the transactions listed can result in the assessment of substantial penalties.

MMCC has implemented the necessary changes to process claims per the standards outlined in the HIPAA statutes.

M. Mailroom and Claims Inventory Controls

The purpose for the review of mailroom and claims inventory controls is to determine if procedures by MMCC ensure that all claims received from providers are either returned to the provider where appropriate or processed by the claims processing system. The review of mailroom and claims inventory controls included a walk through with the mailroom and claims processing personnel. Based on the review, controls in the mailroom and claims inventory controls were adequate.

Nine claims were judgmentally selected from a batch of incoming mail on March 27, 2007. The claims were later researched against information recorded in the claims processing system. Three claims were returned to the providers because there was insufficient information. Five claims were correctly processed with a receipt date of March 27, 2007. One claim was

incorrectly processed with the receipt date of March 30, 2007, three days after the actual receipt date. MMCC should ensure all claims entered in the claims processing system have the actual received date.

Management Comments

MMCC Management concurs. The claim in question was processed with the date the claims was received in the department, which was 3/30 versus the date received by the health plan which was 3/27 in error. To ensure no further occurrences of this nature, MMCC implemented a process whereby all incoming claims are date stamped immediately based on the health plan's received date.

VIII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Provider Complaints

Provider complaints were tested to determine if MMCC responded to all provider complaints in a timely manner. Ten provider complaints were judgmentally selected from a list provided by MMCC. Tenn. Code Ann. § 56-32-226 states:

> The health maintenance organization must respond to the reconsideration request within thirty (30) calendar days after receipt of the request. The response may be a letter acknowledging the receipt of the reconsideration request with an estimated time frame in which the health maintenance organization will complete its investigation and provide a complete response to the provider. If the health maintenance organization determines that it needs longer than thirty (30) calendar days to completely respond to the provider, the health maintenance organization's reconsideration decision shall be issued within sixty (60) calendar days after receipt of the reconsideration request, unless a longer time to completely respond is agreed upon in writing by the provider and the health maintenance organization.

For the ten provider complaints tested, MMCC timely responded to the 2provider. No discrepancies were noted.

Additionally, MMCC's Claims Services Department Policy states that all appeals/complaints are required to be resolved in thirty days. A review of the

provider complaint listing provided by MMCC revealed there were 51 complaints that had not been resolved within 30 days. MMCC should ensure provider complaints are resolved in accordance with its policies and procedures.

Management Comments

MMCC Management concurs that the complaints/appeals in question were resolved beyond the 30 day resolution guideline per internal MMCC policy. However, the complaints in question were resolved within the 60 day response time required by the State. At the recommendation of the State Auditors, MMCC immediately changed its internal policy to coincide with the State policy/guideline of 60 days.

B. Provider Manual

The provider manual outlines written guidelines to providers to assure that claims are processed accurately and timely. In addition, the provider manual informs providers of the correct procedures to follow in the event of a disputed claim. MMCC submitted the provider manual and TDCI approved the manual on August 28, 2006.

C. Provider Agreements

Agreements between an HMO and medical providers represent operational documents to be prior approved by TDCI in order for TDCI to grant a certificate of authority for a company to operate as an HMO as provided by Tenn. Code Ann. § 56-32-203(b)(4). The HMO is required to file a notice and obtain the Commissioner's approval prior to any material modification of the operational documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1). Additionally, the TennCare Bureau has defined through contract with the HMO minimum language requirements to be contained in the agreement between the HMO and medical providers. These minimum contract language requirements include, but are not limited to: standards of care, assurance of TennCare enrollees rights, compliance with all federal and state laws and regulations, and prompt and accurate payment from the HMO to the medical provider.

Per Section 2-9. of the CRA between MMCC and the TennCare Bureau, all template provider agreements and revisions thereto must be approved in advance by the TennCare Division, Department of Commerce and Insurance, in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof. Additionally, Section 2-18. of

the CRA requires that all provider agreements executed by MMCC shall at a minimum meet the current requirements listed in Section 2-18.

Nineteen provider contracts were judgmentally selected and reviewed to determine compliance with CRA requirements. (It is noted not all CRA requirements are applicable to each provider contract.) Twelve of the 19 agreements did not contain all applicable CRA requirements including the provider contract requirements set forth in Section 2-18. MMCC responded to each of the provider contract deficiencies. The following table illustrates the results of the review:

Contract Type	Compliance	MMCC Comment
Ancillary provider agreement/ subcontract	Did not include 12 of 65 applicable CRA requirements	Concurs
Transportation provider agreement	Did not include 25 of 65 applicable CRA requirements	Contract should be updated
Hospital services agreement	Did not include 8 of 60 applicable CRA requirements. The approved template needs to be updated and resubmitted for approval.	Contract amendment required to bring contract into compliance
Risk agreement, PCCM agreement & credentialing	Not submitted for TDCI approval.	Amendments not filed to TDCI in error
Primary care & specialty physician agreement & credentialing	Did not include 19 of 61 applicable CRA requirements	Contract should be updated
Specialty physician agreement	Did not include 13 of 61 applicable CRA requirements	Contract should be updated
Specialty physician agreement	Did not include 20 of 56 applicable CRA requirements	Contract should be updated
Hospital services agreement	Did not include 21 of 58 applicable CRA requirements	Contract should be updated
Primary care physician agreement	Did not include 24 of 59 applicable CRA requirements	Contract should be updated
Ancillary provider agreement	Did not include 23 of 58 applicable CRA requirements	Contract should be updated
Primary care & specialty physician agreement	Did not include 23 of 58 applicable CRA requirements	Contract should be updated
Hospital services agreement	Did not include 21 of 58 applicable CRA requirements	Contract should be updated

Management Comments

MMCC Management concurs. As a result of TDCI's audit findings above, MMCC met with TDCI in May 2007 to determine the best means of correcting contracting deficiencies. The majority of the above deficiencies are the result of MMCC not having updated contracts or amendments on file with these providers to bring the providers individual contract into compliance with current TennCare Contractor Risk Agreement requirements. A number of the deficiencies outlined above are also the result of using TDCI approved contract documents that were deficient at the time of TDCI's approval. MMCC has been making corrective fillings with TDCI since the audit and to date has approval from TDCI of five (5) documents with previous deficiencies.

TDCI compared the 19 contracts selected for testing against previously approved versions submitted by MMCC to TDCI for prior approval. TDCI found that 12 of 19 provider contracts were not submitted to TDCI for approval and did not match approved templates. MMCC should ensure all executed contracts are on the most recent approved template and contain all of the required CRA 2-18 language and provider agreement requirements. MMCC should also submit all unique provider contract templates to TDCI as a material modification to MMCC's certificate of authority as required by Tenn. Code Ann. § 56-32-203(c)(1).

Management Comments

MMCC Management concurs.

D. Provider Payments

Examiners tested capitation payments to providers during 2006 to determine if MMCC complied with the payment provisions set forth in its capitated provider agreements. Review of payments to capitated providers indicated that all payments were made per the provider contract requirements in a timely manner.

E. Subcontracts

HMOs are required to file notice and obtain the Commissioner's approval prior to any material modification of operational documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1). MMCC executed six subcontracts

(three to provide credentialing services and three to provide transportation administrative services) without prior approval of the TennCare Bureau and TDCI in violation of Sections 2.9.f. and 2-17.c. of the CRA and Tenn. Code Ann. § 56-32-203(c)(1). Additionally, MMCC executed a subcontract with an affiliate for medical management services. The subcontract was executed without prior approval of TDCI in violation of Sections 2.9.f. and 2-17.c. of the CRA and Tenn. Code Ann. § 56-32-203(c)(1).

Management Comments

MMCC Management concurs.

F. Non-discrimination

Section 2-24 of the CRA requires MMCC to demonstrate compliance with Federal and State regulations of Title VI of the 1964 Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age of Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981. Based on discussions with various MMCC staff and a review of policies and related supporting documentation, MMCC was in compliance with the reporting requirements of Section 2-24 of the CRA.

G. Stabilization

Section 3-10.h.2(a) of Amendment 4 to MMCC's CRA requires MMCC to comply with the following:

> The CONTRACTOR shall reimburse providers according to reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures in effect as of April 16, 2002, for covered services as defined in Section 3-10.h.2(j), unless otherwise directed by TENNCARE, with funds deposited by the State for such reimbursement by the CONTRACTOR to the provider.

MMCC's management confirmed compliance with all stabilization requirements. During testing of financial, claims processing, and provider contracts, TDCI noted no instances of non-compliance with this CRA requirement.

H. Internal Audit Function

The importance of an internal audit function is to provide an independent review and evaluation of the accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. An internal audit function is responsible for performing audits to ensure the economical and efficient use of resources by all departments to accomplish the objectives and goals for the operations of the department. The internal audit department should report directly to the board of directors so the department can maintain its independence and objectivity.

MMCC's internal auditor reports to the CFO. The internal audit department issues and plans focused reviews with the help of Senior Management. Internal audit staff also prepares the Claims Payment Accuracy Report as required by the CRA. MMCC noted that the Internal Audit Manager reports functionally to the Board of Directors to ensure the integrity and independence of the Internal Audit function. The Internal Audit Manager for administrative purposes reports to the CFO. MMCC provided a copy of the Charter for the Control Assurances Department to support this additional clarification.

I. HMO Holding Companies

Effective January 1, 2000, all HMOs were required to comply with Tenn. Code Ann., Title 56, Chapter 11, Part 2 – the Insurance Holding Company System Act of 1986. Tenn. Code Ann. § 56-11-205 states, “Every insurer and every health maintenance organization which is authorized to do business in this state and which is a member of an insurance holding company system or health maintenance organization holding company system shall register with the commissioner….” MMCC has complied with this statute.

J. Behavioral Health Organization (BHO) Coordination

MMCC was in compliance with Section 2-3.c.2 of the CRA whereby effective July 1, 2002, “claims for covered services with a primary behavioral diagnosis code, defined as ICD 9-CM 290.xx- 319.xx’’ are submitted to MMCC for timely processing and payment.

MMCC is required to refer unresolved disputes between the HMO and BHO to the State for a decision on responsibility after providing medically necessary services. MMCC did not have any ongoing disputes with the BHO.

K. Contractual Requirements for ASO Arrangements

As previously mentioned, effective May 1, 2002, MMCC's CRA was amended so that MMCC would operate as an ASO. As a result, the provisions tested below are requirements for transactions with dates of service after May 1, 2002.

1. Medical Management Policies

   Section 2-2.s. of the CRA requires MMCC to comply with the following as it relates to the TennCare line of business:

   > Agree to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures and medical management policies and procedures as that existed on April 16, 2002, unless otherwise directed or approved by TennCare, and to submit copies of all medical management policies and procedures in place as of April 16, 2002, to the State for purpose of documenting medical management policies and procedures before final execution of this Amendment.

   MMCC's management has confirmed compliance with the requirements described above. During testing of claims processing and provider contracts, no deviations to the requirement were noted.

2. Provider Payments

   Section 3.10.h.2(b) of the CRA states that MMCC "shall release payments to providers within 24 hours of receipt of funds from the State." The check run issued on October 10, 2005 was selected for testing. Based on TDCI's review, MMCC has complied with this provision.

3. 1099 Preparation

   Section 3-10.h.2(c) of the CRA states that MMCC "shall prepare and submit 1099 Internal Service Reports for all providers to whom payment is made." Based on TDCI's review, MMCC has complied with this requirement.

4. Interest Earned on State Funds

   Section 3-10.h.2.(d) of the CRA states interest generated by funds on deposit for provider payments related to the non-risk agreement period

shall be the property of the State. The interest amount earned on the funds reported on MMCC's monthly bank statement should be deducted from the amount of the next remittance request from the TennCare Bureau.

Interest earned for November and December 2006 totaling $50,532 was not returned to the State in a timely manner per Section 3-10.h.2.(d). of the CRA because they were not reduced from the next reimbursement request to the TennCare Bureau as they were earned.

Management Comments

MMCC Management concurs. MMCC has changed its internal process to be sure interest is returned promptly.

5. Recovery Amounts/Third Party Liability

Section 3-10.h.2.(f) and (g) of the CRA require third party liability recoveries and subrogation amounts related to the non-risk agreement period be reduced from medical reimbursement requests of the TennCare Bureau. As third party liability and subrogation amounts are recovered, MMCC should reduce the next medical reimbursement request to the TennCare Bureau for the amounts recovered.

Subrogation amounts collected from September through December 2006 totaling $1,026,857 were not returned to the State in a timely manner per Section 3.-10.h.2.(f) and (g) of the CRA because they were not reduced from the next reimbursement request to the TennCare Bureau as they were recovered.

Management Comments

MMCC Management concurs. MMCC have changed its internal process to be sure all recoveries are returned promptly.

6. Pharmacy Rebates

Section 3-10.h.2.(f) of the CRA states that pharmacy rebates collected by MMCC shall be the property of the State. During the on-site visit, MMCC indicated no further amounts were expected from the PBM for services which ended June 30, 2003.

L. Conflict of Interest

Section 4-7. of the CRA warrants that no part of the amount provided by TennCare shall be paid directly or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to MMCC in connection with any work contemplated or performed relative to this Agreement unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration.

Conflict of interest requirements of the CRA were expanded to require an annual filing certifying that the MCO is in compliance with all state and federal laws relating to conflicts of interest and lobbying.

Failure to comply with the provisions required by the CRA shall result in liquidated damages in the amount of one hundred ten percent (110%) of the total amount of compensation that was paid inappropriately and may be considered a breach of the CRA.

The MCO is responsible for maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization and for including the substance of CRA conflict of interest clauses in all subcontracts, provider agreements and any and all agreements that result from the CRA.

MMCC demonstrated the following efforts to ensure compliance with conflict of interest clause of the CRA:

- The most recently approved provider agreement templates contain the conflict of interest language of the CRA.

- The organizational structure of MMCC includes a compliance officer who reports to the CFO.

- MMCC has written conflict of interest policies and procedures in place.

- The written policies and procedures outline steps to report violations.

- The policy indicates all business associates are to comply with MMCC's conflict policy.

- Employees complete conflict of interest certificates of compliance annually per the written policy and procedures. The certificates were last completed in April 2006.

Provider contract testing noted that all 19 provider agreements reviewed had been amended to include all conflict of interest language set forth in CRA Section 4-7.

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of MMCC.